Testimony in Support of House Bill 5030,

AN ACT MAKING ADJUSTMENTS TO STATE EXPENDITURES FOR THE FISCAL YEAR ENDING JUNE 30, 2015

February 14, 2014

Submitted by: Darcy Lowell, MD, Founder and CEO, Child First, Inc.

Senator Beth Bye, Representative Toni Walker, and distinguished members of the Appropriations Committee:

Good afternoon, my name is Dr. Darcy Lowell and I am here to testify in support of House Bill 5030, AN ACT MAKING ADJUSTMENTS TO STATE EXPENDITURES FOR THE FISCAL YEAR ENDING JUNE 30, 2015.

I want to begin by thanking DCF for their significant funding support for Child First, an evidence-based model that works in the home with very vulnerable young children and families, especially those that suffer from significant mental health problems. These are families who have experienced trauma and other major challenges, like maternal depression, domestic violence, abuse and neglect, substance abuse, and homelessness. DCF has demonstrated a unique understanding of the research on ACEs (Adverse Childhood Experiences) and early childhood brain development, and they are taking a proactive stance to prevent serious mental health, physical health, and academic problems, which are not only costly to the state now, but will dramatically escalate in cost in later years if left untreated. The Child First intervention can save the state substantial funds in child welfare, special education, psychiatric treatment, emergency room and hospitalizations, among others.

Child First was developed right here in Bridgeport, Connecticut, in response to young children and their families who were experiencing major adversity. A randomized controlled trial (RCT) was conducted to prove its effectiveness, showing that the Child First intervention led to significantly decreased child behavioral/mental health problems (42%), decreased language delay (68%), decreased parental depression and other mental health problems (64%), and decreased DCF involvement (39%), sustained at three year follow-up (33%). Child First is now one of the 12 Health and Human Services designated evidence-based models, which are part of the national Maternal, Infant, and Early Childhood Home Visiting initiative (MIECHV).

Our goal was to replicate Child First throughout the state of Connecticut, so that we had an affiliate Child First program in each of the DCF Areas, to meet the needs of these very vulnerable children. Replication of the model in Connecticut was initially supported by a public-private partnership, with over $7.7 million coming from the Robert Wood Johnson Foundation and more than $2.5 million from state and local philanthropy. We have been able to bring $7.9 million to Connecticut (over three years) from MIECHV funding to support replication in an additional five cities, with expansion in three others. Overall, Child First has brought more than $18 million to Connecticut to serve vulnerable families.

We have been extremely successful in our replication of the Child First model. We have provided extensive training, collected both implementation and outcome data from the onset of services, and

demanded that all our affiliate sites meet rigorous benchmarks. We are very pleased to report that our results have surpassed those in our original RCT with 89% of our families improving in at least one major area. For example, 87% of children improved in either social competence or behavior problems; 80% of caregivers experienced decreased depression. (Please see attached document: *Child First: Sample Graphs of Outcomes*.) Furthermore, these findings generally have extremely high statistical significance ($p<.0001$) and large to very large effect size.

We are extremely pleased to report that we now have 15 sites, with a footprint in each DCF Area, but there are many towns which are not covered at all. Our capacity is still very limited, with only 40 teams throughout the entire state. Even though Child First affiliate sites refer children to other programs when they do not have available space, they still have 130 children and families waiting for services. The need for this service in Connecticut is huge. Child First has the potential to save the state millions of dollars if implemented broadly. In fact, we are hoping that we will be able to become part of the State Medicaid Plan in order to leverage the current state expenditures and bring significant federal matching dollars to Connecticut. We are exploring this option with DCF and DSS.

Although we have made significant progress, we are in a precarious position in two of our Child First affiliate sites, Stamford and Middlesex County. Although they are receiving funding from DCF, it is not sufficient for them to continue operations next year, and they will be forced by their Boards to shut their doors. This is a crisis. **We are requesting that DCF appropriate $80,000 more to each of the affiliate sites, for a total of $160,000.** This will give them equal funding with other DCF funded Child First sites around the state. This is the only way that they will be able to continue their critical services to these very vulnerable young children with mental health and other significant challenges.

Connecticut is not alone in its battle to provide needed services to young children with mental health problems. In fact, Child First has been contacted by 25 other states interested in replicating our model. However, our first commitment is to Connecticut. We want our intervention to be an integral part of DCF mental health services, and fully integrated into a comprehensive system of early childhood services within Connecticut. We are very eager to work with the Office of Early Childhood to develop such a system, which will meet the unique needs of all children and families throughout our state.

Once again, we thank DCF for their vision, commitment to the needs of young children, and ongoing financial support. We believe that Child First can make a profound difference in the lives of our most vulnerable children and families.

Respectfully submitted:

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child first

Child First is an intensive, early childhood, home visiting intervention that works with the most vulnerable young children (prenatal to age six years) and their families. The goal is to identify children at the earliest possible time to decrease mental health, developmental, and learning problems, and prevent abuse and neglect.

The Challenge

Scientific research in brain development clearly shows that **high-risk environments** (e.g., where there is maternal depression, domestic violence, substance abuse, or homelessness) lead to levels of stress that can be **"toxic"** to the **young, developing brain.** Without the buffer of strong, nurturing relationships, the results are **long-term damage with decreased learning, behavioral and emotional problems, and poor health.**

The Child First Response

Broad community partnerships lead to early identification of children from very high-risk environments or who show the earliest signs of emotional, behavioral, or developmental problems. Referral to Child First provides:

- **Intensive home visiting intervention:** Comprehensive assessment, well-coordinated family-driven plans, parent guidance, and Child-Parent Psychotherapy are provided in the home by a team of a Master's level Mental Health/Developmental Clinician and Care Coordinator. They provide assessment and mental health consultation in early care and education as a component of this comprehensive approach.
- **Care coordination/case management**: Coordinated, hands-on connection to community resources is provided for all family members, facilitated by strong collaborative relationships through local early childhood systems of care or early childhood councils. This prevents duplication, gaps, and inefficiency.

Child First Works!

The Child First intervention was evaluated with a very high risk population of young children and families. A **randomized, controlled trial** demonstrated that the Child First intervention was both **statistically significant and clinically effective** when compared to Usual Care controls at 12 month follow-up. The results of the randomized controlled trial have been published in *Child Development* in January/February 2011.

Results from the Randomized Controlled Trial

- Child First children were **68% less likely to have language problems**.
- Child First children were **42% less likely to have aggressive and defiant behaviors**.
- Child First mothers had **64% lower levels of depression and/or mental health problems**.
- Child First families were **39% less likely to be involved with child protective services,** sustained at **33% at 3 year follow-up**.
- Child First family members had a **98% increase in access to community services and supports**.

Child First Accomplishments and Impact

- Child First has been designated by HHS as **one of the national evidence-based home visiting models**, eligible for replication funding under the federal Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV).
- Child First now has 15 sites throughout CT, showing the same **excellent evidence-based outcomes.**
- Replication of the model has proceeded through a public-private partnership among the **Robert Wood Johnson Foundation, the CT Department of Children and Families,** and more than 20 other funders, and has been expanded through a major investment by MIECHV.
- Child First's **cost effective** home-based intervention and care coordination cost about $6,900 per family of four, compared to $700,000-$900,000 for one year of psychiatric hospitalization for a single child.
- Child First has been **recognized** by the Coalition for Evidence-Based Policy and the Social Impact Exchange, and highlighted by the Harvard Center on the Developing Child, the Pew Home Visiting Campaign, Zero to Three, the National Conference of State Legislators, and the American and CT Hospital Associations.

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February 2014

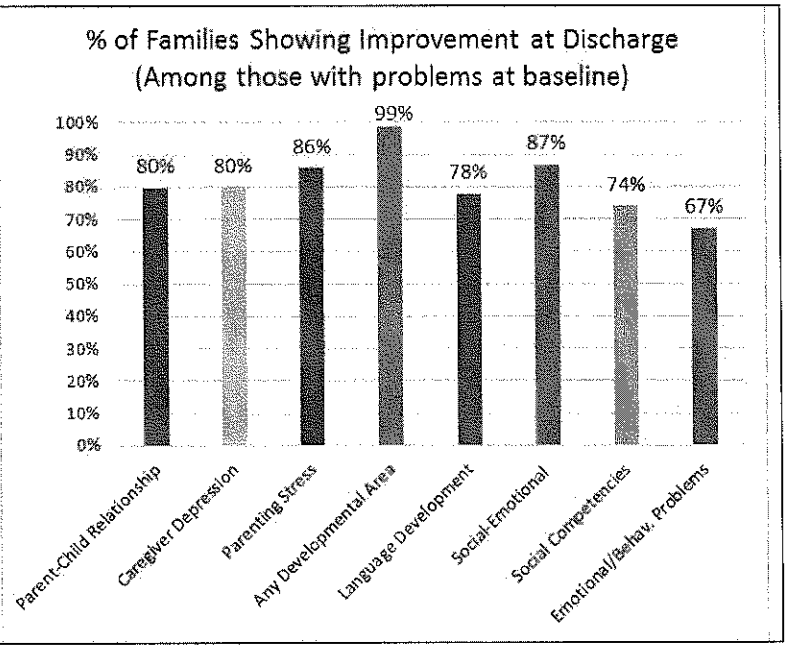
Sample Graphs of Outcomes
Cohorts 1 and 2, Oct 2011 – Sept 2013

OVERALL OUTCOMES

Improvement by Areas

Of those children and parents who had problems at baseline, this graph shows the percentage that had clinical improvement in each area.

Overall 88.6% improved in at least one areas, 69.4% improved in a least two areas, and 54.1% in at least three areas

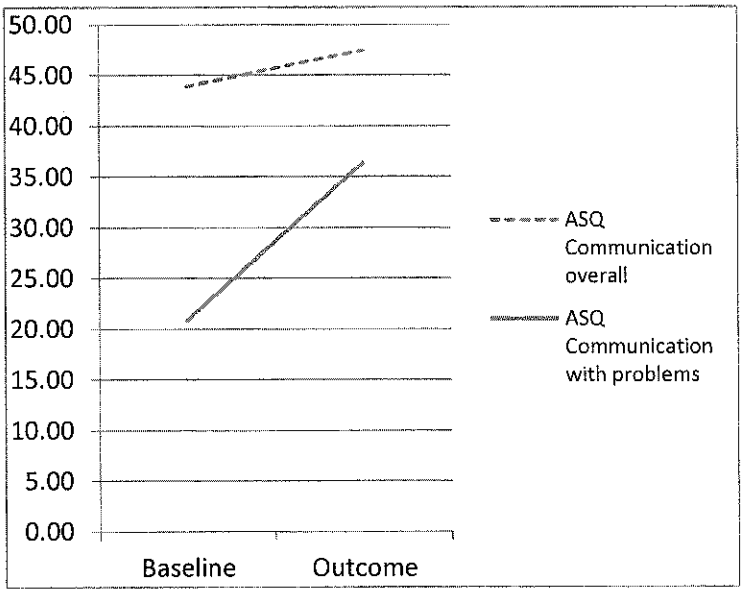


CHILD OUTCOMES

CHILD LANGUAGE
(ASQ Communications)

Language Development showed improvement from baseline to discharge over all families in Cohorts 1 & 2, with dramatic improvement within those that presented with language delay at baseline.

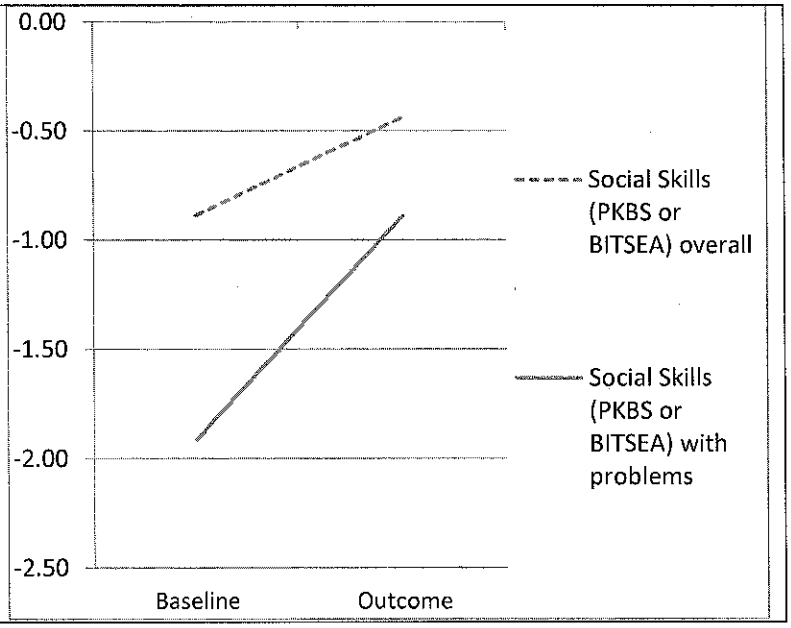
For those that presented with language delay:
$p<0.0001$
Effect size: Cohen's $d=1.06$



SOCIAL SKILLS
(PKBS-2 or BITSEA)

Social Skills showed an improvement from baseline discharge over all families in Cohorts 1 & 2, with dramatic improvement within those that presented with deficits in social skills or competence at baseline.

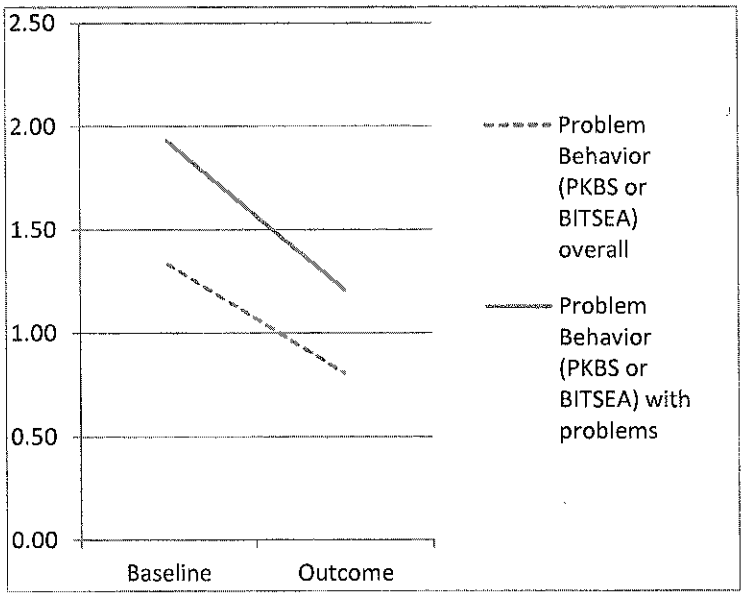
For those that presented with deficits:
$p<0.0001$
Effect size: Cohen's d=.97



PROBLEM BEHAVIORS
(PKBS-2 or BITSEA)

Problem behaviors showed an improvement from baseline discharge over all families in Cohorts 1 & 2.

For those that presented with deficits:
$p<0.0014$
Effect size: Cohen's d=.68

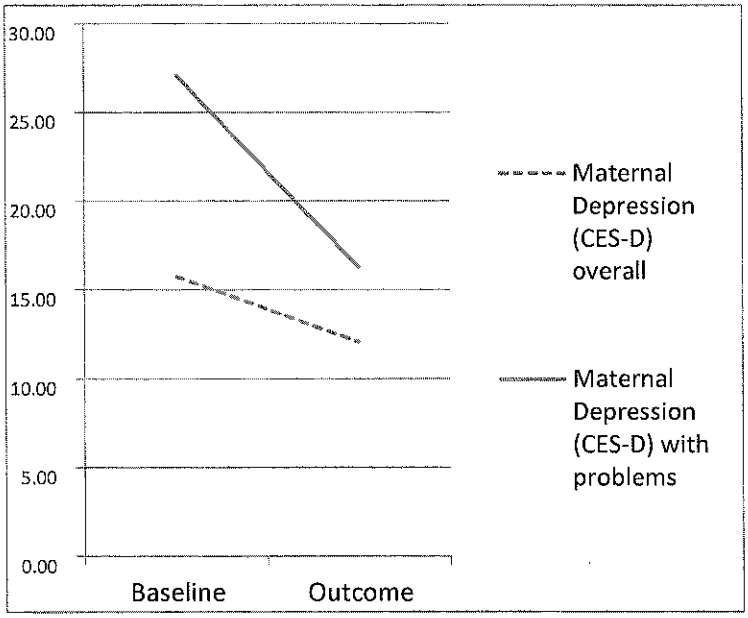


PARENT OUTCOMES

MATERNAL DEPRESSION
(CES-D)

Maternal Depression showed improvement from baseline to discharge over all families in Cohorts 1 & 2, with dramatic improvement within those that presented with depression at baseline.

For those that presented with depression:
$p<0.0001$
Effect size: Cohen's d=1.07



PARENT-CHILD RELATIONSHIP OUTCOMES

PARENT-CHILD INTERACTION
(CCIS)

Parent-child interaction showed very significant improvement from baseline to discharge over all families in Cohorts 1 & 2.

For those that presented with relationship disturbances:
$p<0.0002$
Effect size: Cohen's d=1.12